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AUTHOR Stein, Aaron
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ABSTRACT

Medical and non-medical group mental health approaches are discussed. In the medical approach groups are set up for the treatment of the psychopathology of the members and group therapy or group psychotherapy methods are utilized. The clients are selected by the therapist who determines what kind of group would be most beneficial for the patient. The therapist assumes responsibility for prescribing the treatment and implementing it effectively and safely. Leaders must be qualified as mental health professionals, and have sufficient group training. By contrast non-medical groups supposedly do not deal with psychopathology and instead are concerned with problem solving, self-development, and sensitivity training. Features that distinguish them form medical groups include the establishment of goals other than treatment, no selection of members, no required training for leaders, and a relinquishment for responsibility for possible detrimental effects upon participants. There are many dangers inherent in these conditions and therefore, it is essential that members be screened and selected by leaders, that leaders have necessary training, and that leaders be responsible for protecting clients from undergoing damaging experiences. (RSM)

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GROUP MENTAL HEALTH APPROACHES—
MEDICAL AND NON-MEDICAL MODELS

by

Aaron Stein, M.D.

Associate Clinical Professor of Psychiatry, The Mount Sinai School of Medicine; Associate Attending Psychiatrist and Chief, Adult Group Therapy Division, The Mount Sinai Hospital, New York, N.Y.; Visiting Psychiatrist and Director, Group Therapy Department, Hillside Hospital, Glen Oaks, N.Y.; Supervisory Psychiatrist, Brookdale Hospital Center, Brooklyn, New York.

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In recent years, there has occurred a widespread proliferation of various types of group mental health approaches. Some of these new approaches claim to be therapeutic in their aims; others do not. In addition, they take place under many different kinds of auspices and leadership, and questions have been raised as to possible disturbing effects on some of the participants. A useful approach in evaluating the large number of such recent group approaches is to consider them from the standpoint of those set up according to a medical model, and those set up along non-medical lines. This paper will discuss the medical and non-medical types of group mental health approaches.

The Medical Approach

Beginning with the medical group mental health approach, an obvious but most important point is that the groups are set up in order to help in the treatment of the members whose mental, emotional, and adjustment problems have led to a disturbance or impairment of function—a mental or emotional illness. Therefore, these are therapeutic groups set up for the treatment of the illness or psychopathology of the group members.

Another obvious, but even more important point, is that the members commit themselves to the group for treatment; they acknowledge they are ill and are patients, and are participating in the group for the sake of the treatment of their symptoms, problems, etc., which are the manifestations of their illness. The therapist undertakes to treat the patients; he assumes the responsibility for recommending or prescribing the treatment and for seeing to it that it is carried out as effectively and safely as is possible. The full acknowledgment by both members and leader that the therapeutic group is set up for the sake of treatment, is a specific characteristic of the medical group approach and distinguishes it clearly from the non-medical type.

A direct result of this is that the patients for the therapeutic groups are selected by the therapist. This again is in sharp distinction from many of the non-medical groups. The therapist examines the patient or prospective member, takes a history, and utilizes a variety of diagnostic measures to determine the nature and degree of the patient's illness, the type of treatment required, and whether or not he is in suitable condition to undertake group therapy, etc. (If group therapy is unsuitable, other treatment measures are recommended.)

Having determined that a therapeutic group is indicated as the proper treatment for the patient, the therapist must then determine the most useful kind of group for the patient. The considerations involved have been described elsewhere (Stein, 1963), and will not be gone into at this point. The group selected needs

to be one in which the patient will be able to participate effectively and will benefit from the participation in the group without being subjected to stresses that might be too disturbing to him. Similarly, in putting a patient into a therapeutic group, care has to be exercised that he is selected so that he will join in facilitating the work of the group and not hinder it, so that his participation will be helpful and not disturbing to other members of the group.

These are obvious points, but they are basic for the medical type of group therapy. The medical mental health approach is, therefore, characterized by the careful selection of patients for the therapeutic group and by an equally careful selection of the group for the patient. A specific function of the leader in the therapeutic group is to make these selections.

The medical group mental health approaches utilize two kinds of group methods—group therapeutic methods and group psychotherapeutic methods.

Group therapeutic approaches include activity groups and therapeutic participation groups. In activity groups, the groups are set up so that its members can engage in a common activity—sports, dance, drama, artwork, building a shed, etc. The activity itself is the therapeutic agent, arranged to benefit the members psychologically and otherwise. Activity groups, of course, are also formed under non-medical auspices, but when they are established under medical direction—in a hospital, half-way house, or a clinic, etc.—they are used to activate and help socialize

withdrawn or disturbed patients of all ages whose illness has prevented them from undertaking this or other kinds of activity. There may or may not be group discussion in these activity groups, but care must be taken to insure that they center around the activity and not the individual members' problems. The members of the group establish a relationship with the leader who is usually a trained mental health worker, and he functions to help the members participate as fully as possible in the group activity.

In the <u>therapeutic participation groups</u>, groups are arranged to facilitate the participation of the members in the interaction occurring in the group. Active participation in the group is the essential therapeutic agent, with each member finding a role to fill in the life of the group.

This type of group is widely used by the therapeutic milieu and the therapeutic community in hospitals and half-way houses, in order to facilitate the activation and socialization of patients by encouraging them to interact and participate with others in the protected community of the therapeutic group.

The interaction in therapeutic groups helps the patient become aware of some of the attitudes and reactions, and actions that they show and some of the feelings connected with these, but it does not lead towards an awareness or an investigation of underlying psychopathology. The therapeutic effects of the therapeutic groups in the therapeutic community are largely obtained through activation, stimulation, and result from the support and gratification of the transference needs of the patients. The staff and the other patients

act as good parental figures, good siblings, helping the patients move actively towards better control of integration and better participation and socialization with the other patients.

The second type of group mental health approach is group psychotherapy proper. Small groups are set up for investigation, and treatment of the individual member is psychopathology. The three essential conditions (Foulkes and Anthony) of the psychotherapy group are that the group relies solely on verbal communication; that the individual member is the object of the treatment, and that the group itself—or more accurately, the group interaction—is the main therapeutic agency.

Accordingly, in-group psychotherapy utilizes a group and a group method in performing psychotherapy. The relationships that are established and the interactions that occur are utilized to further the free flow of group discussions that constitute the group psychotherapy. Varying degrees of intensity and uncovering are utilized in the different types of group psychotherapy, depending upon to what extent resistance and the transference are interpreted. Analytic group psychotherapy is the most intensive type; modified or supportive group psychotherapy is the next less uncovering or intensive, and group counseling and group guidance are the least uncovering or intensive with much support and gratification being provided for the patients by leaving much of the resistance, and especially the transference, uninterpreted (Stein, 1969).

In group psychotherapy proper, (and indeed, in all spontaneously formed small groups) the relationships of the members to the

leaders and between the members themselves, are the important dynamic factors that determine the nature of the interaction in the group (Freud, 1921, Stein 1964). These stem from changes in the way the transference is manifested in group psychotherapy.

There are two important ways in which the manifestations of the transference are changed in group psychotherapy: (1) the intensity of the transference directed toward the therapist is lessened (diluted, diminished, etc.); and (2) the transference is split (diverted, fragmented, etc.), since it is directed toward the other patients in the group as well as toward the therapist.

Taking the first of these changes in the transference, a diminution in intensity of the transference drives directed toward the leader is a necessary condition for the therapeutic work in the group. It results from the presence of the group as indicated above and is facilitated by the group therapist <u>limiting his own interaction with the members of the group</u>. This is an important difference from many non-medical groups.

The need to inhibit and deflect the transference from the leader to the group members leads to an increase in the <u>intra-group</u> tension between the members. In this way, despite its diminished intensity and altered manifestations, the transference to the leader continues to operate as one of the essential major dynamic factors in the group. This intra-group tension, based upon an inhibited and generally uninterpreted transference to the leader in group psychotherapy, leads to intensified <u>inter-member</u> transference reactions in the group. Patients utilize roles in the group, based upon unconscious fantasies, to act-out and interact with one another and to try to

get the other patients to act-out transference roles and conflicts. The availability of the group members as multiple transference objects who are realistically present in the group, and who will actually respond to transference manifestations, results in group member interactions which thus can be designated as a therapeutic type of interaction and acting-out in the group session. This initial unconscious uninterpreted response of one member to another's transference occurs in a very real fashion in the group session, and a major function of the therapist is to insure that it occurs in the group session and not outside of it, so that it is available for the therapeutic work in the group.

From the above, it is clear that in group psychotherapy proper the leader sets up conditions, including limitation of his own interaction with group members, in order to facilitate members' therapeutic participation and interaction in the group. In order for the leader to do this effectively, he must undergo thorough training in group psychotherapy. Requiring the leader to have adequate qualifications as a mental health professional, and requiring him further to have adequate training in performing group psychotherapy (including the selection of patients and setting up a group as well as conducting the group therapy) specifically characterizes the medical approach to group therapy and distinguishes it from the non-medical approach.

The Non-Medical Approach

The non-medical mental health group approaches, by contrast, do not, supposedly, deal with illness or psychopathology. A variety

of group approaches are used for purposes, allegedly other than treatment. Because of this, it is doubtful whether they should be called mental health group approaches, even if they are designated as "non-medical" mental health approaches.

The non-medical group approaches are directed toward achieving many different kinds of goals. MacLennan (1969) has summarized these most usefully. By following and amplifying her scheme, the following types of non-medical (she classifies the medical groups as analytic) may be listed: problem-solving groups, existential (or self-improvement, or self-betterment, or self-expanding) groups, and sensitivity-training groups. She points out that widely different assumptions are made in the different approaches, and that many of the groups are based on the belief that experiences in groups are an important aspect of learning.

In helping people to deal with various types of specific reality problems, a variety of groups have been set up. These have included remedial education groups, vocational training groups, the older type of street-clubs and the newer types of subsidized, work-training groups not infrequently coupled with a coffee-house type group discussion and social action programs. Obviously, most of these group approaches would be designated either as activity groups or as therapeutic groups, in terms of the descriptions previously given. In general, while some of them may include a certain degree of group counseling in helping the participants become aware of conscious emotional reactions, they are not set up for treatment and they do not constitute medical psychotherapy groups in terms of the uncovering and investigation of unconscious, individual

psychotherapy. In most of these groups, the members help each other with problems and the leader, who is usually trained, acts as coordinator, clarifier, facilitator, resource person.

A special type of problem-solving group is the one set up to help patients deal with alcoholism and the addictions. Properly speaking, these are medical groups and the dynamics and relationships described elsewhere (Stein 1969) may be summarized by saying they are special types of guidance groups in which the transference needs of the members receive support and gratification from the uninterpreted member interaction. However, many of these groups, particularly the addict confrontation/encounter groups in half-way houses, etc., are set up under non-medical auspices and are led by "indigenous, non-professional" leaders, including ex-alcoholics and ex-addicts who have little or no training in conducting groups. In addition, many, if not most of these non-medical addict groups utilize techniques adapted from the existential type of group—active manipulation by the leader and deliberate pressure from the other members of the group. The limitations and dangers of this type of approach will be discussed later.

Another special type of problem that is increasingly dealt with by a special type of group approach is the problem of disturbances in the family. Very frequently, this is seen as a medical problem in relation to a member of the family who has developed mental or emotional illness, and then it is treated under medical auspices. However, at other times family group discussions are set up under non-medical auspices: schools, community centers, churches, etc. The point to be stressed here is that often the techniques used

are similar to those in the existential group approaches—active participation of the leader, setting himself up as a model, etc. —with the limitations and dangers attendant upon this.

Turning now to the existential groups or the self-betterment, or self-improvement, or self-expanding groups these are, to quote MacLennan, "concerned with quality of encounters between persons in-the-moment. They seek to enhance people's capacity to live now, to feel, to experience, to be expressive, and to trust sufficiently to allow themselves to be open and to reveal the real self to the other. Along with this, is the demand to reveal oneself to oneself. In these groups, the assumption is made that the intensity of feeling and openness in the group promotes a capacity for intimacy there and in real life. . . . All these groups are concerned with learning about the self image, about being genuine and real." They all believe that by free expression and exposure in the group experience, potential growth and expansion of self occurs.

In this type of group, the existential type, the newer and more controversial developments in group approaches have occurred. A well known one is the marathon or pressure-cooker group in which a group meets for 24, 36, or up to 72 hours in more or less continuous sessions. The idea is that the continuous interaction forces confrontation and speeds up the therapeutic process. Additional techniques have been used, with or without the marathon session, to heighten interaction. These include dance therapy, nude groups, sensory experience (touching and feeling) groups as adjuncts to encounter groups to practice awareness of sensory experience and sharpen the acuteness of the senses (e.g., Yoga,

Zen-Buddhism, etc.), marathons utilizing deliberate techniques to heighten aggressive interaction, etc.

In these groups, the role of the leader is not differentiated from that of members. He participates actively in the group discussions and interactions, and uses his reactions, etc., to serve as a model for other members of the group. Many such leaders use the groups to deal with their own problems and state this is a necessary condition for setting up an effective existential type of group.

This active, emotional participation of the leader, combined with the utilization of techniques to manipulate and pressure the participants into increased emotional interaction (including exhortations to confess, Mowrer in Gazda, 1968) led to Cowle's (1969) statement that "I find a model for the whole movement in the religious revival. What is [considered] good about these therapies is exactly what has been felt for many thousands of years to be good about the phenomenon of 'religious enthusiasm' with its exultation, its anti-critical attitude, its immediacy, its relinquishment of self to group or cosmic influence, and so on. The elements are almost exactly parallel. In the crash (existential) group we find a dropping of pretenses at covering up one's inner thoughts and feelings; a tendency to ventilate with fervor one's shortcomings and difficulties; a pervasive sense of being on trial but also supported through it by a sense of inspiration and exaltation; a profound submission to the group and particularly the leader; a final feeling of having been transformed, redeemed, having one's life set completely anew on a hopeful and constructive pathway,

and the belief that this will carry on indefinitely, saving one from past sins and difficulty. Interchange the language a little and you get the language of a revival movement."

In many, if not most of these groups, the leaders may have little or no training. Often, participation in one of these groups is considered sufficient to enable the participant to set up and lead groups of his own—e.g., the non-professional aide, the ex-addicts, etc. As MacLennan states, the leaders often "are not clinicians and/or they have no training in group theory or management. Many groups are poorly run by charlatans, quacks, or amateurs."

In many of these groups, there is no selection of members, and some who work with this type of group insist that <u>non</u>-selection is a necessary condition for the openness and trust with which the group must operate, e.g., whoever comes, belongs and is accepted into the group (Mowrer and others, in Gazda 1968).

The possible dangers inherent in these conditions are obvious and are cited by Cowles and MacLennan and others. The participants in these groups are manipulated and subjected to great pressure to interact as freely and as vigorously as possible. Consequently, intense emotional reactions develop with a forced and rapid reduction of defenses and "the stirring up of libidinal drives without adequate integration with other facets of the personality. . . ." Severe disturbances—psychotic breaks, suicide attempts, etc.—can and do result and are beginning to be reported in the literature (Corsini 1968; Jaffe & Scherl, 1969). MacLennan raises the important

question concerning these non-medical groups: "To what extent should a group leader be responsible for protecting the members of his group from embarking on experiences which may be detrimental to them?"

The third type of non-medical group is the so-called "T-Group" or "Sensitivity Training Group." These were originally set up to teach group dynamics in college courses, in the training of group therapists and psychiatric residents, and to others—educators, executives, foremen, and supervisors, management officials, personnel officers, labor-management coordinators—to help them utilize group dynamics in establishing effective communication and relationship between groups of people. The groups are organized in a very specific way to accomplish this specific task—the teaching and learning of group dynamics. They are, in Maclennan's words, "concerned with the universalities of group process and of highlighting these through lack of structure (of the training group), interpretation of group phenomena and emotional language so that the processes are easy for the members to identify and understand. . . . The groups may be concerned with intra- or inter-group phenomena. . . . The leader's role is highly differentiated from that of the members' and is highly structured in these groups. In some schools, such as the Tavistock Clinic in England, training of the leader is rigorously required. In others, such as the Bethel group associated with the National Training Laboratory, there is [only] an initial training period" and after this, participants can and do lead sensitivity training groups of their own. In the Tavistock groups, participants are screened and carefully selected; in the Bethel group this is not done at all.

Originally, discussion and interaction in the sensitivity training groups were carefully limited to the intra- and inter-group phenomena and discussion and/or confrontation of the member's personal emotional reactions and problems was avoided. Even in the most skilled hands, this was difficult to do and when inadequately trained leaders, lacking clinical background, led these groups, they often encouraged confrontation of the members with their personal difficulties without adequate preparation, leading to the same dangers of disturbing effects as was noted in the existential groups. Two recent reports cite examples of this (Redlich and Astrachan, 1969).

This survey of non-medical group approaches has indicated the important features that distinguish them from the medical approach: setting up of goals other than treatment (denial of illness in many instances), no selection of members, no required training for the leader and a relinquishment (deliberately, often) of responsibility for possible detrimental effects upon the members of participation in the group.

In conclusion, some obvious but important facts become apparent as a result of comparing medical and non-medical group approaches. These are that some screening and selection of participants in group discussions—especially those that will stimulate emotional interactions—is most desirable if not absolutely necessary; that this should be the responsibility of the leader; that the leader should have the necessary training to accomplish this and should seek competent consultation or supervision, or both, and that the leader should be responsible for protecting the members of his group

from embarking upon or undergoing experiences which may be detrimental to them. A group leader who is not qualified, or who will not or cannot do this should not lead—or should not be permitted to lead—any group in which any considerable degree of emotional interaction is liable to occur. These requirements are similar to those required of a teacher, a priest, or minister, a nurse or physician.

Aaron Stein, M.D.
1140 Fifth Avenue
New York, N.Y. 10028

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